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The Relationships between Enmeshment, Overprotectiveness, and Anorexia Nervosa Symptoms in College Women

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THE RELATIONSHIPS BETWEEN ENMESHMENT, OVERPROTECTIVENESS, AND ANOREXIA NERVOSA SYMPTOMS IN COLLEGE WOMEN

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ABSTRACT

The purpose of this study is to examine Minuchin's (1974) description of the anorectic family as having a characteristic style of interaction described as enmeshment and overprotectiveness. Thirty-eight women completed a questionnaire requesting demographic information, The Psychological Separation Inventory, and The Eating Disorders Inventory-2. It was hypothesized that enmeshment and overprotectiveness, two characteristics of the "psychosomatic family", would significantly influence the etiology and maintenance of anorexia nervosa. The results suggested that there are significant relationships between the Eating Disorder Inventory and the Psychological Separation Inventory. Identifying the sample as characteristic of an eating disorder is unwarranted, however, this sample shows symptomatology of lack of psychological separation.

INTRODUCTION

During the transition from childhood to adulthood, adolescents encounter numerous challenges (Graber, Gunn, Paikoff & Warren, 1994). Adolescence is the time for the separation-individuation process, and has become the prime time for the onset of eating disorders (Smolak & Levine, 1993; Strober & Humphrey, 1987). Separation-individuation can be defined as the normal developmental sequence of achieving "a sense of separate individual entity" (Friedlander & Siegel, 1990). The process of separation-individuation involves a gradual resolution of the conflict between maintaining a feeling of connection in family relationships and the establishment of autonomy in the individual (Perosa & Perosa, 1993). This requires that the adolescent seeks a balance between adaptive forms of cohesiveness and maladaptive forms of separateness from parents as he or she gains independence and establishes a sense of self that is distinct (Perosa & Perosa, 1993).

Problematic family structure and communication within a family can be related to the development of eating disorders (Leon, Fulkerson, Perry & Dube, 1994; Pole et al, 1988; Stern et al, 1989; Waller, Calam, & Slade, 1989). Problems with separation-

individuation, in particular, play a role in the maintenance as well as etiology of eating disorders (Friedlander & Siegel, 1990; Kenny & Hart, 1992). Minuchin, Rosman and Baker (1978), have described in detail how a child's eating problems serve a control function in highly enmeshed families, in which individual autonomy, an essential step in the process of separation-individuation, is forbidden.

Clinicians have stressed the role of family dynamics in the development of eating disorders (Barbarin & Tirado, 1985; Brone & Fisher, 1988; Johnson & Flach, 1985; Strober & Humphrey, 1987; Waller, 1994; Waller, Calam & Slade, 1989). Minuchin et al. (1978) described the anorectic family as having a characteristic style of interaction, including rigidity, enmeshment, poor resolution of conflicts, and overprotectiveness (Johnson & Flach, 1985; Kog, Vandereychken & Vertommen, 1985). Enmeshment is a structural characteristic referring to the intensity of boundaries within the family (Kog, Vertommen & Vandereychken, 1987). Enmeshed boundaries are characterized by parental overinvolvement. The flow of thought and feeling between parent and child is so intrusive that the adolescent does not feel separate but instead smothered (Perosa & Perosa, 1993). Rigidity refers to the degree of adaptability of the family interaction, otherwise known as the resistance to family change. Overprotectiveness implies excessive parental involvement in children's affairs (Calam, Waller, Slade, & Newton, 1990). Lack of conflict resolution refers to a limited amount of negotiation of conflicts in the family or to a lack of divergence in opinions (Kog, Vertommen & Vandereychken,

1987). Families with an anorectic patient are often characterized by this family organization pattern (Kog, Vertommen & Vandereychken, 1987).

For the understanding and treatment of eating disorders, it is important to understand Bowlby's Attachment Theory. The major idea of Bowlby's theory is the "attachment system". He defines the word "attachment" as a bond between two individuals, one as the source of security for the other. This sense of security in the "attachment system" is reinforced by constant interaction with attachment figures. Young adults are often struggling with identity formation and intimacy issues which involve the reworking of relationships (Brone & Fisher, 1988; Strober & Humphrey, 1987). During this period of reworking of relationships, separation anxiety is considered a normal phenomenon which is evoked by disruptions in the individual's sense of safety and connectedness. This separation distress is often used by young adults as a way to enable them and their attachment figures to regain their closeness and find alternative support (Humphrey & Stern, 1988). There are a variety of problems that result from the disturbances in the "attachment system", in particular "anxious attachment". "Anxious attachment" is characterized by separation distress, as well as some psychological consequences, such as phobias, low self-reliance and separation depression. According to Bowlby's theory, we can expect to find an association between "anxious attachment" and disturbed self-reliance. Armstrong and Roth (1989) examined Bowlby's theory and found differences in both frequency and intensity of "anxious attachment" in the eating

disorder sample as compared to a normal comparison group. The eating disorder group had considerably less coping skills.

The purpose of this thesis is to study the symptoms of a "psychosomatic family" with the eating disorder known as anorexia nervosa focusing on the two characteristics that have been found most significant in the onset of anorexia nervosa, enmeshment and overprotectiveness (Barbarin & Tirado, 1985; Brone & Fisher, 1988; Calam et al, 1990; Johnson & Flach, 1985; Perosa & Perosa, 1993; Strober & Humphrey, 1987; Telerant et al, 1992). Understanding the psychological mediators between family interactions and psychopathology will help in both the prediction and the treatment of eating disorders (Calam, Waller, Slade & Newton, 1990). It is hypothesized that significant correlation's will be found between subscales of The Eating Disorders Inventory and The Psychological Separation Inventory, demonstrating that psychological separation influences the development and maintenance of an eating disorder.

CHAPTER II

LITERATURE REVIEW

The following research has been summarized to identify the influence family environment, family interaction, and the separation-individuation process have on eating disorders in adolescents.

Family Environment and Family Interaction

It is essential to understand the importance of the family environment and the role it plays in an individual's psychological growth. The following studies have found family environment and family interaction essential in predicting and treating eating disorders. In a study by Leon, Fulkerson, Perry and Dube (1994), they found that the development of eating disorders may be related to problematic family structure and communication within that family. They hypothesized that (1) adolescents and their parents with a high and moderate risk for eating disorders would each be consistently more negative in their perception of family adaptability, cohesion, parent-adolescent communication, and satisfaction with their families than a noneating disordered comparison group; (2) a greater history of eating disorders, mood disorders and substance use disorders would be present in risk group family members as well as a greater concern about weight and dieting; and (3) behaviors in the school setting would be less positive in the eating disorder risk groups. The families of 181 adolescents, 45 males and 136 females (grades 7-10), in a predominantly Caucasian middle class suburban school

district participated in this study. Subjects were classified as high risk for eating disorders, moderate risk for eating disorders, or placed in a comparison group, based on scores on a 21-item risk index. This results investigation concluded that family structure and processes are perceived more negatively by female eating problem groups. Of the three hypotheses, the first hypothesis was supported. This investigation suggests that there is an association between female risk status for the later development of an eating disorder and potential family difficulties related to differential perceptions of the quality of family interactions.

In a study by Berman, Heiss & Sperling (1994) continued attachment to parents was correlated with measures of adjustment in both school and peer situations at least through the transition to college. The study examined the psychometric properties of the Continued Attachment Scale-Parent Version which measures cognitive and emotional responses to perceived separation from parents. Data from 216 college students was collected. Scores on the scales used were highly correlated with attachment scale scores that measure support, encouragement, and closeness. Correlation's with measures of emotional state and personality differed for men and women, however, the correlation's suggested that the scale assessed a distinct domain of experience related to continued closeness to parents and to depression (Berman, Heiss & Sperling, 1994). This investigation suggests that the more attached a child is to his/her parents, the more difficult the adjustment process may be in school and peer situations. Another

investigation by Armstrong and Roth (1989) was completed examining the association between familial relations and the onset of an eating disorder. They examined the relationship between separation and attachment difficulties and eating disorders. Separation and attachment problems have been consistently identified as a major factor in eating disorders, primarily anorexia nervosa (Armstrong & Roth, 1989). It was hypothesized that eating disorder individuals would manifest "anxious attachment" and separation-based depression. The purpose of this study was to establish that the difficulties shown by the eating disorder group show unique and characteristic qualities indicating chronic and severe "anxious attachment". Participants for this study were 27 participants who were referrals to an Eating Disorders Unit. Of the 27 subjects, 11 were diagnosed as anorectic, 12 were diagnosed as bulimic, and the remaining subjects were classified as atypical eating disorders. This study chose to contrast its findings with research that had been completed on non-clinical subjects who were in the process of separation-based developmental issues with varying degrees of success or difficulty. This study found that 96% of the eating disorder sample evidenced "anxious attachment" and 85% of the eating disorder sample evidenced chronic separation depression. The data suggested that the eating disorder subjects manifested both "anxious attachment" and separation-based depression. The results demonstrated that in both frequency and intensity the anxious attachment of the eating-disorder sample differed significantly from the normal comparison groups.

Kinzl, Traweger, Guenther, & Biebl (1994) examined the possible relationship of negative early familial experiences and childhood sexual abuse to the later development of eating disorders. Three questionnaires were distributed to 202 female university students. There were no significant differences in the total or the subscale scores on the Eating Disorder Inventory among women with no, one, or repeated incidents of sexual abuse. However, women who reported an adverse family background displayed significantly higher Eating Disorder Inventory total and subscale scores than did women who assessed family background as a secure base. The data suggests that childhood sexual abuse is neither necessary nor sufficient for the later development of an eating disorder, while an adverse family background may be an important etiological factor.

Further investigation was completed by Mallinckrodt, McCreary, and Robertson (1995), where childhood attachment, family environment, and adult social competencies were examined to explain the association between sexual abuse and eating disorders. 102 female college students and 52 female clients sexually abused in childhood, completed ten surveys. Significant associations were found between family environment, incest, social competencies, and eating disorders. Incest survivors had more dysfunctional families and lower social competencies than did nonabused women. Among incest survivors, those with the lowest levels of social competencies and poorest bonds with their mothers had more eating disorder symptoms.

A study was done by Calam, Waller, Slade and Newton (1990) that investigated whether parental overprotection prevented offspring from developing autonomy, that then

impacts the amount of control they have over their own lives. This perceived lack of control over one's own life is a major factor seen in some classifications of eating disorders. Therefore, the idea that perceived overprotection should be a common feature in the family of a member who goes on to develop an eating disorder was examined. It was hypothesized that patients with eating disorders would describe their parents as overprotective. The participants of the study consisted of 98 women. All participants were asked to complete the Parental Bonding Instrument (Parker et al, 1979). The study found a trend towards higher perceived protection and lower perceived care by both parents of the women with eating disorders. The women with eating disorders in this particular study identified their mothers as lacking in care, while they identified their fathers as overprotective and low in caring. Overall, the results do support the hypothesis that overprotection could be associated with anorexia nervosa.

A study performed by Hoffman and Weiss (1987) examined psychological separation from parents, parental conflict and dominance, and parental symptoms, i.e. a parent's behavior may serve as a model for the adolescent, particularly if it is a successful means of gaining attention, in relation to the common presenting problems of college students. In a random sample of 83 male and 107 female college students from intact families, a direct relation was found between the degree of interpersonal conflict in the family and interpersonal distress among family members as reported by the student. They found that the greater the degree of conflictual dependence of the student on either or both parents, the more symptoms the student reported. The following instruments

were used: the Inventory of Common Problems (Hoffman & Weiss, 1986); the Psychological Separation Inventory (Hoffman, 1984); and the Interparental Conflict and Influence Scales (Schwarz & Getter, 1980). Parental symptoms were found to be related to students' presenting problems, with emotional dependence serving as an important mediating variable (Hoffman & Weiss, 1987).

The afore-mentioned studies suggest that problematic family environment and family interaction are essential to the prediction of a host of symptomatic behaviors. The studies found an association between complications in family environment and family interaction with the later development of an eating disorder.

Separation-Individuation Process

Perosa and Perosa (1993) investigated whether the existence of undifferentiated, overly involved relationships, and misalignments between parent and child. They found that these factors place pressure on the young adult and hinders the separation-individuation process. The purpose of this study was to examine the separation-individuation process in young adulthood by investigating the relationship between Minuchin's structural family model and adolescent identity formation and coping processes. It was hypothesized that young adults who described their families as having distinct boundaries and weak cross-generational alliances and as disclosing and resolving conflict would report that they were "identity achieved" and that they maintained positive coping processes. The participants were 182 college students. The results of this study partially support Minuchin's theory that a balance between enmeshment and

disengagement is essential in a family in order for the development of a stable identity and the use of positive coping strategies by young adults.

In a study performed by Schultheiss & Blustein (1994), it was hypothesized that the conjoint variance of psychological separation and parental attachment is more strongly related to college student development and adjustment than either set of variables in isolation. Schultheiss & Blustein (1994) tested the hypothesis that conflictual and attitudinal independence and adolescent-parent attachment are positively associated with college student development and adjustment. Measures were administered to 139 students attending a large state university in the Northeast. The results of this investigation suggested that psychological separation and parental attachment are more strongly related to college student development and adjustment as a conjoint hypothesis for women but not for men. The results suggested that for both men and women, college student development is positively associated with college student adjustment. Further, it is important to assess the nature of the association between family relationships and development (Schultheiss & Blustein, 1994).

Another investigation was completed by Friedlander and Siegel (1990) that asserted that problems with separation-individuation play a role in the maintenance as well as the etiology of eating disorders. Friedlander and Siegel tested the difficulties associated with separation-individuation and a set of cognitive-behavioral indicators characteristic of anorexia nervosa. It was hypothesized that less psychological separation and individuation along with more diffuse parent-child boundaries would predict a

greater number of cognitive and behavioral distortions characteristic of anorexia nervosa. The participants consisted of 124 undergraduate and graduate women. There were three self-report measures including: the Psychological Separation Inventory (Hoffman, 1984); the Differentiation of Self scale (Olver et al, 1989); the Permeability of Boundaries Scale (Olver et al, 1989); and the Eating Disorder Inventory (Garner & Olmstead, 1984). The conclusions of this investigation support the theoretical assumptions about familial factors that contribute to the onset and maintenance of eating disorders and the potentially serious consequences for young women who fail to reach a sense of psychological separateness.

In a study performed by Hoffman (1984), an attempt was made to provide a conceptualization of different aspects of adolescent psychological separation from their parents. Four scales reflecting psychological separation were defined: functional, emotional, conflictual and attitudinal independence. Correlation's were performed between the Psychological Separation Inventory (Hoffman, 1984), and the Personal Adjustment scale on the Adjective Check List (Gough & Heilbrun, 1980), using a sample of 75 male and 75 female college students. The results showed that greater conflictual independence was related to better personal adjustment, particularly with regard to love relationships. Emotional independence was found to be related to better academic adjustment (Hoffman, 1984).

The afore-mentioned studies suggest that problems with the separation-

individuation process do play a role in the etiology and maintenance of an eating disorder.

Anorexia Nervosa In Adolescents

The following studies focus on eating disorders, in particular, anorexia nervosa. These studies take into consideration all three predictors, the importance of family environment, family interaction and the separation-individuation process and how they correlate with the etiology and maintenance of anorexia nervosa. A study done by Felker and Stivers (1994) examined the impact of gender and family environment on the potential for developing anorexia nervosa in adolescents. It was hypothesized that there would be a difference in adolescents' perceptions of family environment when comparing eating disordered to non-eating disordered individuals. Data was collected from 393 voluntary participants. The instruments used in this particular study were the Family Environment Scale (Moos & Moos, 1981), and the Setting Conditions for Anorexia Nervosa Scale (Slade et al, 1986). The participants who were considered "at risk" recorded a higher mean score on perceived family conflict and control, but a lower mean score on the subscales of expressiveness, cohesion, independence, and organization. Furthermore, the female subjects who were considered "at risk" scored higher on the achievement orientation and control subscales than did their male counterparts. Lower independence, greater conflict and control were all found to be significantly associated with the development of an eating disorder. The Family Environment Scale scores identified a perception of lower cohesion, lower organization, lower expressiveness, and

lower independence to be associated with a greater risk of developing an eating disorder. In addition, a perception of greater control, greater conflict, and greater achievement orientation was found to be associated with an increased risk of developing an eating disorder. The multiple regression analysis identified a significant relationship between family environment and the risk of developing an eating disorder in adolescents.

A study was completed by Dare, LeGrange, Eisler, and Rutherford (1994) that redefined the psychosomatic family, focusing primarily on the family processes of eating disorder families. These investigators studied two forms of family intervention for the management of eating disorders in adolescents. In this article, they describe a study of 26 families with an adolescent suffering from an eating disorder. Expressed Emotion in the families of both anorexic and bulimic patients were at low levels. The results suggested low levels of parental Critical Comments might be taken to represent the conflict avoiding character of the families of psychosomatic patients. The Family Adaptability and Cohesion Evaluation Scale for family organization scored by patients and parents, equate with the clinical descriptions of enmeshment and lack of boundary structure. The findings of this study amplify the clinical theories which emphasize excessive closeness, overinvolvement, and lack of conflict in families with an eating disorder member.

Waller, Slade and Calam (1990) did research on rigid, enmeshed family interaction as a causal factor in anorectic and bulimic disorders (Minuchin, Rosman & Baker, 1978). It was found that the families of anorexics were characterized as having unusual degrees of "blurring of generational boundaries" (Waller, Slade & Calam, 1990).

It was hypothesized that levels of adaptability and cohesion in the family were useful in distinguishing anorexic and bulimic women from women without eating disorders. The participants for the study were 68 females. Two questionnaires were used: the Eating Attitudes Test (Garner & Garfinkel, 1979), and the Family Adaptability and Cohesion Evaluation Scale (Olson et al, 1982). The results found that the women with eating disorders perceived their families as lower in adaptability and cohesion than the comparison group. Further, there were differences in perceived family interaction between the women with and without the diagnosed eating disorders.

A study concerning family interaction patterns was completed by Harding and Lachenmeyer (1986). They contended that overprotection, enmeshment, and rigidity characterized families with a member who had been diagnosed with anorexia nervosa. It was hypothesized that the anorexic participants would identify more family overprotection, enmeshment, rigidity, and less conflict resolution than would a group of non-anorectic controls. They further hypothesized that the anorectic participants would be more external in their control orientation. It was also predicted that the three variables of overprotection, rigidity, and enmeshment would be significantly better predictors than the control variable. The participants consisted of 60 individuals. The results of this study were that the anorectics were significantly higher on overall I-E scores and significantly more external than the controls. Anorectics were found to maintain a sense of personal ineffectiveness with concern for achieving control over the events in the world around them (Bruch, 1973).

Heebink, Sunday & Halmi (1995) compared adolescents and adults with anorexia nervosa and bulimia nervosa, eating disorder symptomalogy and comorbid affective and anxiety states. Two hundred fifty female inpatients on an eating disorder unit were studied. Patients were divided into categories based on age, diagnosis, and menstrual status. The onset of anorexia nervosa before age 14 and primary amenorrhea were associated with the greatest maturity fears during acute illness. For patients with restricting anorexia, adolescents aged 17 through 19 years had the highest drive for thinness compared to adolescents aged 13 through 16 years and adults. The lowest levels of depression and anxiety were seen in patients younger than age 14 with restricting anorexia. The data suggests that in older adolescents, the wish to be thinner, issues of body image, and social pressures may be a more effective focus of psychotherapy.

Shugar and Krueger (1995) evaluated family communication during systemic family therapy with 15 hospitalized anorexics. They used a Family Aggression Scale (Krueger, 1995), and the Eating Attitudes Test (Garner, Olmstead, Bohr & Garfinkel, 1982). Initially members communicated aggression covertly. This finding may partially explain the common clinical observation that the families of anorexics present a strong facade of togetherness and avoid overt conflict. The findings of this study suggest that family aggression as measured by the Family Aggression Scale is an index of pathology in anorexics' families and is also a clinically meaningful measure of improved conflict resolution during systemic family therapy (Shugar & Krueger, 1995).

Patterns of late adolescent separation-individuation was investigated by Smolak and Levine (1993). They examined the reaction of bulimic-like versus anorexic-like college women to late adolescent separation-individuation. Families of restricting anorexics were hypothesized as more enmeshed, overprotective and unresponsive to their daughter's self-expression. Therefore, the daughter at risk for developing anorexia nervosa may find the process of separation-individuation inhibited by familial factors, making her overly dependent on her parents (Bruch, 1973). These authors examined how the process of separation-individuation differs for girls who eventually develop restricting anorexia nervosa versus those who will develop bulimia nervosa. It was hypothesized that relative to women without eating disorders, anorexic-like women would be underseparated, whereas the bulimic-anorexic-like women would be overseparated. A total of 198 individuals participated in the study. Each participant completed the Psychological Separation Inventory (Hoffman, 1984); the Eating Disorders Inventory (Garner, Olmstead & Polivy, 1983); and the DSM-III-R Symptom Checklist (APA, 1987). The study found that anorexic-like women showed more conflictual dependence on both parents than did non-eating disordered women. The restricting anorexics mean scores for the Psychological Separation Inventory were below any of the other participants. The anorexics show greater dependency in 15 out of the 16 comparisons. Furthermore, they also had lower scores on the emotional, attitudinal and functional independence scales. All of the anorexic women scored in at least the 25th percentile on

the Eating Disorders Inventory on the Maturity Fears subscale, which infers that there is greater separation anxiety and nurturance seeking by restricting anorexics.

The afore-mentioned studies clarify the relationships between numerous challenges adolescents encounter during the transition to adulthood and the onset of eating disorders.

CHAPTER III

METHODOLOGY

Participants

Participants for this study were 38 female undergraduate students, with a mean age of 18.2 years, from a small, private college in the Midwest region. The entire sample consisted of freshman college women. Of the participants, 95% were Caucasian, and 5% were African American or Puerto Rican. 100% of the participants reported a family income in excess of $50,000. The decision to use college-age students was based on the fact that the transition from low identity status, for example, diffusion and dependence, to identity achievement, is enhanced by the college experience. The private college targeted predominantly Caucasian, upper middle class females, who have been identified as the greatest risk group (Graber et al, 1994).

Measures

Demographic Questionnaire: Participants were asked to identify their age, race, family income, and year in college on the cover sheet.

Psychological Separation Inventory (PSI) (Hoffman, 1984): This measure is a 138-item questionnaire, that contains four scales pertaining to a late adolescent's relationship with each parent and reflects the process of psychological separation. The four subscales are as follows: (1) Functional Independence, which is the individual's ability to manage

his/her personal matters without parental assistance, i.e. "My mother's/father's wishes have influenced my selection of friends"; (2) Emotional Independence, which is the amount of freedom reported by the individual in regard to excessive togetherness and the need for support and approval from parents, i.e. "My mother/father is the most important person in the world to me"; (3) Conflictual Independence, which is the amount of freedom reported by the individual in regard to excessive distrust, guilt, responsibility, or resentment towards the individual's parents, i.e. "Sometimes my mother/father is a burden to me"; and (4) Attitudinal Independence, which is the reported values, beliefs, and attitudes that differ between the individual and her parents, i.e. "My ideas regarding racial equality are similar to my mother's/father's". All of the above items were rated on a 5-point scale ranging from "not at all true of me"(1) to "very much true of me"(5). These ratings are reversed and subtracted from the total score possible so that higher scores reflect greater psychological separation. Participants were asked to identify their interpersonal struggles with their parents. Internal consistency (between .84 and .92), and test-retest reliability are excellent (Hoffman, 1984), and construct validity has been established based on significant, theoretically predicted associations with various adjustment problems of college students (Hoffman & Weiss, 1987).

Eating Disorder Inventory-2 (EDI) (Garner, 1990): This measure is a 91-item questionnaire that provides standardized subscale scores on eight dimensions that are clinically relevant to eating disorders. These dimensions are as follows: Drive for

Thinness, which assesses excessive concern with dieting, preoccupation with weight, and fear of weight gain, i.e. "I feel extremely guilty after overeating"; Bulimia, which assesses the tendency to think about and engage in bouts of uncontrollable overeating, i.e. "I have gone on eating binges where I have felt that I could not stop"; Body Dissatisfaction, which assesses dissatisfaction with the overall shape and with the size of those regions of the body which are of greatest concern in one's life, i.e. "I think my stomach is too big"; Ineffectiveness, which assesses feelings of general inadequacy, insecurity, worthlessness, emptiness, and lack of control over one's life, i.e. "I wish I were someone else"; Perfectionism, which measures the extent to which one believes that personal achievement should be superior, i.e. "As a child, I tried very hard to avoid disappointing my parents and teachers"; Interpersonal Distrust, which assesses an individual's general feeling of alienation and reluctance to form close relationships and to express thoughts and feelings to others, i.e. "I have trouble expressing my emotions to others". Interoceptive Awareness, which measures confusion and apprehension in recognizing and accurately responding to emotional states, i.e. "I get confused about what emotion I am feeling"; and Maturity Fears, which assesses the desire to retreat to the security of childhood, i.e. "The happiest time in your life is when you are a child" (Garner, 1990). Included in the EDI-2 are three additional subscales. These provisional subscales are the following: Asceticism, which measures the tendency to seek virtue through the pursuit of spiritual ideals such as self-discipline, self-denial, self-restraint, and control of bodily urges, i.e. "I am ashamed of my human weaknesses"; Impulse

Regulation, which assesses the tendency toward impulsivity, substance abuse, recklessness, hostility, destructiveness in interpersonal relationships, and self-destructiveness, i.e. "I have to be careful of my tendency to abuse alcohol"; and Social Insecurity, which measures the belief that social relationships are tense, insecure, disappointing, unrewarding, and generally of poor quality, i.e. "I feel like I am losing out everywhere" (Garner, 1990). It consists of 91 items presented in a six-point format requiring respondents to answer whether each item applies "always", "usually", "often", "sometimes", "rarely", or "never". Higher ratings reflect more extreme attitudes and behaviors. Reliability estimates for the EDI show adequate internal consistency (.80 for an eating disorder sample), and criterion validity has been well established (Garner, 1990).

Procedure

Participants were solicited through informational letters sent directly to their school address, identifying the purpose of the research and when and where it would take place. The researcher also attended Introduction to Psychology classes to introduce the study and solicit students to participate. Professors would give psychology students credit to participate in the research. The psychology students who participated were seen in the psychology department laboratory. The other participants were notified to meet in a conference room in the basement of the freshman dormitory. The purpose of the study was presented as research on how family interactions are related to individual development and coping styles. The participants were all informed that this was thesis

research and that all information would be confidential. The participants were asked to fill out an informed consent form and then the questionnaires were distributed. All participation was voluntary and anonymous. Each participant was notified that if at any time during the experiment that they felt any discomfort, they had the right to leave before completion. The questionnaires took approximately thirty minutes to complete and upon completion, each participant was given a debriefing statement including information on mental health referrals if any discomfort was experienced.

CHAPTER IV

RESULTS

Descriptive Analyses

In reference to the results of the Psychological Separation Inventory, higher scores reflect greater separation-individuation and greater psychological separation. Each of the four subscales of the PSI were divided into a mother and father scale. To score the PSI, each subscale had a total which was subtracted from the total possible for that scale, scoring mother and father scales separately. On the first subscale, Functional Independence-Mother, the mean was equal to 26.5 (SD=11.5), and for Functional Independence-Father, the mean was equal to 35.3 (SD=12.1). The total possible score was 65 for each. The second subscale, Emotional Independence-Mother, the mean was equal to 36.6 (SD=14.9), and for Emotional Independence-Father, the mean was equal to 42.0 (SD=16.7). The total possible score for this scale was 85. The third subscale, Conflictual Independence-Mother, the mean was equal to 71.3 (SD=15.8), and for Conflictual Independence-Father, the mean was equal to 74.8 (SD=13.8). The total possible score was 125. The fourth subscale, Attitudinal Independence-Mother, the mean was equal to 23.7 (SD=11.5), and for Attitudinal Independence-Father, the mean was equal to 28.1 (SD=14.3). The total possible score for this scale was 70. In addition, for the PSI total, the mean was equal to 350.8 (SD=62.2), and the maximum score was 690.

Table 1.1 contains a summary of these findings.

For the Eating Disorder Inventory-2, higher ratings reflect more extreme attitudes and behaviors about eating and body image. In comparison with published norms for anorexia nervosa in nonpatient college females, approximate percentile ranks for this sample of predominantly nonpatient college females were the following: Drive for Thinness, the mean was equal to 7.3 (SD= 5.2), which equates to the 73rd percentile. This suggests that 73% of a nonpatient college sample had more extreme concerns and preoccupation with dieting than this college sample. For Bulimia, the mean is equal to 13.8 (SD=4.5), which equates to the 99th percentile. This suggests that 99% of the nonpatient college sample had more tendencies to engage in bouts of uncontrollable overeating than this sample. For Body Dissatisfaction, the mean is equal to 5.9 (SD=5.9), which equates to the 42nd percentile. This means that 42% of the nonpatient college sample are more dissatisfied with the overall shape of their body than this sample. For Ineffectiveness, the mean is equal to 16.4 (SD=6.1), which equates to the 99th percentile. This suggests that 99% of a nonpatient college sample had more feelings of inadequacy and insecurity than the current sample. For Perfectionism, the mean is equal to 3.4 (SD=3.8), which equates to the 36th percentile. This suggests that 36% of a nonpatient college sample had stronger beliefs than this sample that personal achievement should be superior. For Interpersonal Distrust, the mean is equal to 10.3 (SD=5.3), which equates to the 98th percentile. This means that 98% of a nonpatient college sample had stronger feelings than the current sample of alienation and reluctance to form close

relationships. For Interoceptive Awareness, the mean is equal to 13.5 (SD=5.3), which equates to the 99th percentile. This suggests that 99% of a nonpatient college sample stated more confusion and apprehension in recognizing emotional states than this sample. In conclusion, for Maturity Fears, the mean is equal to 8.8 (SD=4.4), which equates to the 98th percentile. This suggests that 98% of a nonpatient college sample studied had a stronger desire to retreat to childhood than the current sample. All of the above information leads us to assume that this particular sample is healthier than other samples. There was a lack of normative data to compare with the three EDI provisional subscales. Following are the means and standard deviations of these three provisional subscales: Asceticism, M=12.2 (SD=3.9); Impulse Regulation, M=19.7 (SD=5.4); and Social Insecurity, M=11.4 (SD=5.1). Table 1.2 contains a summary of these findings.

Quantitative Analyses

Correlational analyses were calculated to assess the relationship between the Eating Disorder Inventory variables and the Psychological Separation Inventory variables. Statistical significance was found between a few of the subscales of the EDI and the PSI. The EDI subscale, Interpersonal Distrust and the PSI subscale, Functional Independence-Mother, were statistically significant, R=.4163, $p<.01$. The EDI subscale, Interpersonal Distrust and the PSI subscale, Functional Independence-Father, were statistically significant, R=.3950, $p<.05$. As an individual's general feeling of reluctance to form close relationships and to express thoughts or feelings to others increased, an individual's ability to manage their personal matters without parental assistance was

likely to be higher. Thus, partial support was found for the research hypothesis. Also, statistically significant were the following relationships: Interpersonal Distrust and Emotional Independence-Mother, R=.4122, p<.05; Interpersonal Distrust and Emotional Independence-Father, R=.3934, p<.05. As an individual's general feeling of reluctance to form close relationships and to express thoughts or feelings to others increased, the amount of freedom reported by the individual in regard to excessive togetherness and the need for support and approval from parents was likely to be higher. Also significantly related were Interpersonal Distrust and Conflictual Independence-Father, R=.4388, p<.01, As an individual's general reluctance to form close relationships and to express thoughts or feelings to others increased, the amount of freedom reported by the individual in regard to excessive distrust, guilt, responsibility, or resentment towards the father was likely to be higher. Interpersonal Distrust and Attitudinal Independence-Father, R=.4135, p<.01 was also significantly related. As an individual's general feeling of reluctance to form close relationships and to express thoughts or feelings to others increased, the reported values, beliefs, and attitudes that differ between the individual and her father was likely to be higher. A significant relationship was found between Interoceptive Awareness and Conflictual Independence-Father, R=.3373, p<.05, As confusion and apprehension in recognizing and accurately responding to emotional states increased, the amount of freedom reported by the individual in regard to excessive distrust, quilt, responsibility, and resentment towards the individual's father was likely to be higher. Interoceptive Awareness and Attitudinal Independence-Father, R=.4332, P<.01 was also

significantly related. As confusion and apprehension in recognizing and accurately responding to emotional states increased, the reported values, beliefs, and attitudes that differ between the individual and her father was likely to be higher. Social Insecurity and Conflictual Independence-Father, $R=.4562$, $p<.01$ were related as well. As the belief that social relationships are tense, insecure, disappointing, unrewarding, and generally of poor quality increased, the amount of freedom reported by the individual in regard to excessive distrust, guilt, responsibility, and resentment towards the individual's father was likely to be higher. Finally, the relationship between Social Insecurity and Attitudinal Independence-Father, $R=.4307$, $p<.01$ was significant. As the belief that social relationships are tense, insecure, disappointing, unrewarding, and generally of poor quality increased, the reported values, beliefs, and attitudes that differ between the individual and her father was likely to be higher. Table 1.3 contains a summary of these findings.

CHAPTER V

DISCUSSION

It was hypothesized that the subscales of the Eating Disorder Inventory and the subscales of the Psychological Separation Inventory would be significantly related. There was statistical significance found between some of the EDI and PSI subscales. There were significant relationships found between Interpersonal Distrust and Functional Independence and Emotional Independence from both parents. These were the only relationships found significant for both parents. This may be interpreted as the more reluctance the individual has in forming close relationships with others, the more confidence the individual has in managing personal matters without parental assistance and the more freedom the individual reports in regard to needing support and approval from parents. This relationship suggests that an individual accepts more responsibility and is more self-sufficient in his/her life when the mother is involved. A mother may have more confidence in her child's ability to be independent. The mother and child relationship begins where the mother is the protector, however, the child spends adolescence trying to separate from the mother.

The remaining relationships that exist were found to be significant with the father only. A significant relationship was found between Interpersonal Distrust and Conflictual Independence and Attitudinal Independence from the father only; between

Interoceptive Awareness and Conflictual Independence and Attitudinal Independence from the father only; and Social Insecurity and Conflictual Independence and Attitudinal Independence from the father only. Interpretation of these relationships suggest the importance the father plays in the daughters development. The first relationship a daughter builds in her life is with her father. This is the first male companion that she trusts and with whom she shares an emotional attachment. She spends most of her adolescence strengthening the father-daughter relationship and begins to generalize these feelings she has towards her father to other outside relationships. This may influence an attraction to other male companions that enter her life. As a result of this joining between father and daughter, the daughter comes to appreciate the father's qualities, characteristics, and morals, and tends to value those aspects in other individuals. Individuals may experience reluctance to form close relationships with others because of their confusion around the role that a man in their life is suppose to play. They may become inadequate at forming healthy relationships and understanding their own role in these relationships.

The father usually plays a role in families as the one in control. Because of the bonding between father and daughter, the father tends to take the role as the one in control of the daughter. The father will come to expect the best from the daughter which begins to be interpreted as pressure to be perfect. The daughter may then begin to accept different morals and values from the father in hopes of sabotaging the idea of perfection and success.

Research has supported that individuals conflictually dependent on their parents are most at risk for developing an eating disorder (Skowron et al, 1994). The combination of Attitudinal Independence and Conflictual Independence suggests something more extreme than a simple escape from family members (Smolak et al, 1993). The EDI subscales, Drive for Thinness, Body Dissatisfaction, Perfectionism, and Ineffectiveness, are considered characteristics of women with eating disorders (Skowron et al, 1994). However, the only EDI subscale that was significant in this sample was Ineffectiveness and Interoceptive Awareness. Without evidence suggesting the presence of these subscales, the diagnosis of an eating disorder may be unwarranted.

In conclusion, all of the above interpretations are important because they are highlighting the characteristics of the individuals in this particular non-patient college population. The characteristics that would need to be found in an individual to warrant the diagnosis of an eating disorder are not found to be significant in this particular population. Therefore, this suggests that even though we cannot conclude that this population can be diagnosed with an eating disorder, we can associate some of the characteristics of an underseparated family relationship with this sample.

Limitations

The limitations of this study are as follows. A sample size of 38 is small, thus making generalizing to the entire targeted population difficult. The sample size was successfully targeted to the white, upper middle class female. However, it has become

more common for eating disorders to be in all socioeconomic classes and different cultures (Felker et al, 1994). Therefore, the generalizability of these results are constrained and more supportive results may have been found with adolescent girls from other ethnic and socioeconomic backgrounds. Furthermore, Berman et al. (1994) found that continued attachment during the first weeks of the semester predicted depressed mood at the end of the semester for men only. In other words, this may indicate that continued attachment scales are most useful in the context of a relatively acute separation from an attachment figure. For example, sampling the junior or senior undergraduate students may be a more representative of the risk taking population.

A second limitation is the use of self report measures. Research has shown that self report measures can lack internal consistency, due to the amount of extraneous variables that may effect an individual's responses. There is a problem in drawing conclusions based on our student cohort. In such a voluntary and anonymous study of any college or university population, it is very difficult to be certain of its representativeness. A study could be done with eating disorders, not only by questionnaires, but by face to face interviews (Kinzl et al, 1994). The use of observational instruments within different settings may establish and strengthen the generalizability and validity of these measurements. Furthermore, a self report questionnaire makes the assumption that family members can make the appropriate judgments that are needed (Dare et al, 1994). The self report measures may also have been influenced by social desirability (Schultheiss et al, 1994). Each of the subscales

were completed from the perspective of the adolescent, which may have produced a biased view of the adolescent-parent relationship (Felker et al, 1994; Perosa et al, 1993). For the PSI, the fact that the total scores depend on recall and perceived relationships limit its objective validity (Calam et al, 1990). Again, the lack of significance between the variables used in this research may be due to the possibility that the participants experienced difficulty accurately recalling family transactional patterns. Perhaps these same variables would emerge as more significant if they were assessed in a sample of adolescent anorexics who still reside with their families. The final limitation of self report measures, specifically with the topic of eating disorders and enmeshment in families is that most individuals even if they do not have eating disorder behavior may not label their family as enmeshed. Further, they may not understand the concept of overprotectiveness or enmeshment and until they have experienced a therapeutic session or continuous therapy. In other words, individuals may not know or feel their family interaction is problematic until the disorder has been identified.

Third, in any study concerning these familial interactions, the low levels of criticism and the absence of expressed hostility, may represent the same or similar processes of the families overtly avoiding the expression of differences between family members (Dare et al, 1994). These are characteristic of distressed families in general and they do not seem unique to eating disordered families (Stern et al, 1989). In conclusion, without the evidence suggesting the presence of these psychological variables: drive for

thinness, body dissatisfaction, perfectionism, and sense of personal ineffectiveness, the diagnosis of an eating disorder may be unwarranted (Skowron et al, 1994).

Implications

As a result of this study performed on the influence of the psychosomatic family and its influence on anorexia nervosa, many implications for counseling have been identified. First of all, results of the study may have positive impact on the prevention of eating disorders through the implementation of appropriate identification processes and prevention strategies. The ability to identify the risk groups is perhaps the first step in developing prevention and intervention programs to offset the health risks of disturbed eating behaviors. Interventions may lead to a decrease in prevalence and improvement in the recovery time of individuals who have developed an eating disorder (Felker et al, 1994). It would be wise for college counselors to develop preventative programs that focus primarily on the separation issues common to individuals at this stage of life.

Second, the results of this research identified the importance of looking at the father-daughter relationship and how it effects an individuals development of autonomy. It further suggests that individual therapy focusing on family relationships, specifically the role the father plays in the individuals development, would be a necessity in the treatment process. The implications for the individual to understand how family has influenced their own development is an essential part of recovery. The therapist will concentrate on disengaging the family, asserting family members' competence and individuality, and furthering conflict resolution (Brone et al, 1988). In family therapy,

family members would not be allowed to speak for each other and competent acts, those of the anorexic, are highlighted. The emphasis of therapy should be on developing a sense of autonomy in the anorexic adolescents (Brone et al, 1988). Counseling may be beneficial for individuals who are preparing to go away to college. Family concerns must be discussed when helping young adults confront developmental tasks as they psychologically leave home (Perosa et al, 1993). This way the young adult can integrate meaningful experiences into a coherent sense of self (Perosa et al, 1993).

Furthermore, there are appropriate techniques for this clientele. Felker (1994) states that teaching conflict resolution skills and developing strategies for coping with angry feelings would be beneficial. The counselor can help the adolescent become better prepared to deal with conflict within the family unit. It is important to teach communication skills to the anorexic individual and the family members. It is essential to be able to communicate effectively especially at times of distress. The enhancement of self awareness and understanding may help the adolescent to develop greater independence from the family structure. Deficiencies that are identified in the family environment of those adolescents at risk may be addressed through education. Improvement of interpersonal skills, self-concept, and organizational skills may impact the family in positive ways (Felker et al, 1993). Felker (1994) has used assertiveness training which has lead to self disclosure and ultimately helped the individual to develop more personal independence. Since the anorexic population feels that they do not have control over any part of their own lives, it is important to give them encouragement that

they can achieve control over events in the world around them. It is very important through the presentation of facts about weight control that the therapist should counter unrealistic expectations from family or individuals and to replace these fantasies with realistic goals. It would be beneficial to prepare family members and the individual that treatment is a long struggle. The therapist can be helpful by suggesting to the family ways to expand their ways of giving support (Barbarin et al, 1985).

This study has reinforced the benefits of using measures, such as the EDI and the PSI, to aid in the prediction of eating disorders. By using a nonclinical sample, we are able to see the validity in the prediction measures. This study has further reinforced the importance of studying familial patterns and their influence on eating disorders. It has strengthened the need for the father to be involved in therapy and the father daughter relationship to be studied thoroughly in the treatment of eating disorders as an essential part of treatment and recovery. It has identified the father as playing a major part in the symptoms of this disease. This study has identified the issues that are essential to be worked through in order for an individual to recover from this disease and gain control over his/her own life. The evidence found in this study may encourage counselors to adopt an integrated treatment approach for eating disorders.

This study has demonstrated the etiological and therapeutic importance of studying separation and attachment processes in eating disorder individuals. Freidlander and Siegel (1990) have described the development of the typical client's difficulties:

Coming from a dysfunctional family structure, one in which individual

> differentiation is not valued or promoted, a young woman finds it difficult to achieve a mature sense of herself apart from her parents. Reluctant to do so, yet increasingly confronted with complex developmental tasks that require a certain level of individuation, the client's sense of personal adequacy continues to diminish. By focusing exclusively on eating, weight, and body image, she can confine her thoughts and behaviors-and, consequently, her anxiety-to one sphere. She is unable to discriminate between emotions and hunger sensations. She is immature and distrusts others. In severe cases the disorder also keeps her realistically tied to her parents, which reduces her conflicts about dependency and thus helps her avoid undertaking life tasks for which she feels inadequately prepared (p. 77).

In conclusion, the results of this study suggested that characteristics of the "psychosomatic family" do have implications on an individuals development and may be a symptom of the eating disorder known as anorexia nervosa. The EDI subscales, Interpersonal Distrust; Interoceptive Awareness; and Social Insecurity, all were significant in predicting results on the subscales of the PSI, Functional Independence; Emotional Independence; Conflictual Independence; and Attitudinal Independence. The results of this study and the research completed for this study, infer that understanding the psychological mediators between family interactions and psychopathology will be beneficial in both the prediction and treatment of anorexia nervosa. It has identified the importance of understanding family relationships and how they can influence the development of an individual.

APPENDIX

WRITTEN CONSENT FORM

Project Title:_____

I, _____, state that I am over 18 years of age and that I wish to participate in a research project being conducted by _____.

I acknowledge that _____ has fully explained to me the risks involved and the need for the research; has informed me that I may withdraw from participation at any time without prejudice; has offered to answer any inquiries which I may make concerning procedures to be followed; and has informed me that I will be given a copy of this consent form.

In the event that I believe that I have suffered any emotional discomfort as the result of participation in the research program, I may contact the Chairperson of the Institutional Review Board for the Protection of Human Subjects for the Lake Shore, Water Tower and Mallinckrodt Campuses of Loyola University (telephone: (312) 508-2471).

I freely and voluntarily consent to my participation in the research project.

_____

(Signature of Investigator) (Date)

_____

(Signature of Subject) (Date)

DEMOGRAPHIC INFORMATION

YEAR IN COLLEGE:_____ AGE:_____

FAMILY INCOME:_____ RACE:_____

EDI-2 ITEM BOOKLET

David M. Garner, Ph.D.

DIRECTIONS

Enter your name, the date, your age, sex, marital status, and occupation. Complete the questions on the rest of this page. Then turn to the inside of the booklet and carefully follow the instructions.

Name _____ Date _____

*Age _____ Sex _____ Marital status _____ Occupation _____

A. *Current weight: _____ pounds

B. *Height: _____ feet _____ inches

C. Highest past weight excluding pregnancy: _____ pounds

How long ago did you first reach this weight? _____ months

How long did you weigh this weight? _____ months

D. *Lowest weight as an adult: _____ pounds

How long ago did you first reach this weight? _____ months

How long did you weigh this weight? _____ months

E. What weight have you been at for the longest period of time? _____ pounds

At what age did you first reach this weight? _____ years old

F. If your weight has changed a lot over the years, is there a weight that you keep coming back to when you are not dieting? ___ Yes ___ No

If yes, what is this weight? _____ pounds

At what age did you first reach this weight? _____ years old

G. What is the most weight you have ever lost? _____ pounds

Did you lose this weight on purpose? ___ Yes ___ No

What weight did you lose to? _____ pounds

At what age did you reach this weight? _____ years old

H. What do you think your weight would be if you did not consciously try to control your weight? _____ pounds

I. How much would you like to weigh? _____ pounds

J. Age at which weight problems began (if any): _____ years old

K. Father's occupation: _____

L. Mother's occupation: _____

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INSTRUCTIONS

First, write your name and the date on your EDI-2 Answer Sheet. Your ratings on the items below will be made on the EDI-2 Answer Sheet. The items ask about your attitudes, feelings, and behavior. Some of the items relate to food or eating. Other items ask about your feelings about yourself.

For each item, decide if the item is true about you ALWAYS (A), USUALLY (U), OFTEN (O), SOMETIMES (S), RARELY (R), or NEVER (N). Circle the letter that corresponds to your rating on the EDI-2 Answer Sheet. For example, if your rating for an item is OFTEN, you would circle the O for that item on the Answer Sheet.

Respond to all of the items, making sure that you circle the letter for the rating that is true about you. DO NOT ERASE! If you need to change an answer, make an "X" through the incorrect letter and then circle the correct one.

---

1. I eat sweets and carbohydrates without feeling nervous.
2. I think that my stomach is too big.
3. I wish that I could return to the security of childhood.
4. I eat when I am upset.
5. I stuff myself with food.
6. I wish that I could be younger.
7. I think about dieting.
8. I get frightened when my feelings are too strong.
9. I think that my thighs are too large.
10. I feel ineffective as a person.
11. I feel extremely guilty after overeating.
12. I think that my stomach is just the right size.
13. Only outstanding performance is good enough in my family.
14. The happiest time in life is when you are a child.
15. I am open about my feelings.
16. I am terrified of gaining weight.
17. I trust others.
18. I feel alone in the world.
19. I feel satisfied with the shape of my body.
20. I feel generally in control of things in my life.
21. I get confused about what emotion I am feeling.
22. I would rather be an adult than a child.
23. I can communicate with others easily.
24. I wish I were someone else.
25. I exaggerate or magnify the importance of weight.
26. I can clearly identify what emotion I am feeling.
27. I feel inadequate.
28. I have gone on eating binges where I felt that I could not stop.
29. As a child, I tried very hard to avoid disappointing my parents and teachers.
30. I have close relationships.
31. I like the shape of my buttocks.
32. I am preoccupied with the desire to be thinner.
33. I don't know what's going on inside me.
34. I have trouble expressing my emotions to others.
35. The demands of adulthood are too great.
36. I hate being less than best at things.
37. I feel secure about myself.

38. I think about bingeing (overeating).
39. I feel happy that I am not a child anymore.
40. I get confused as to whether or not I am hungry.
41. I have a low opinion of myself.
42. I feel that I can achieve my standards.
43. My parents have expected excellence of me.
44. I worry that my feelings will get out of control.
45. I think my hips are too big.
46. I eat moderately in front of others and stuff myself when they're gone.
47. I feel bloated after eating a normal meal.
48. I feel that people are happiest when they are children.
49. If I gain a pound, I worry that I will keep gaining.
50. I feel that I am a worthwhile person.
51. When I am upset, I don't know if I am sad, frightened, or angry.
52. I feel that I must do things perfectly or not do them at all.
53. I have the thought of trying to vomit in order to lose weight.
54. I need to keep people at a certain distance (feel uncomfortable if someone tries to get too close).
55. I think that my thighs are just the right size.
56. I feel empty inside (emotionally).
57. I can talk about personal thoughts or feelings.
58. The best years of your life are when you become an adult.
59. I think my buttocks are too large.
60. I have feelings I can't quite identify.
61. I eat or drink in secrecy.
62. I think that my hips are just the right size.
63. I have extremely high goals.
64. When I am upset, I worry that I will start eating.
65. People I really like end up disappointing me.
66. I am ashamed of my human weaknesses.
67. Other people would say that I am emotionally unstable.
68. I would like to be in total control of my bodily urges.
69. I feel relaxed in most group situations.
70. I say things impulsively that I regret having said.
71. I go out of my way to experience pleasure.
72. I have to be careful of my tendency to abuse drugs.
73. I am outgoing with most people.
74. I feel trapped in relationships.
75. Self-denial makes me feel stronger spiritually.
76. People understand my real problems.
77. I can't get strange thoughts out of my head.
78. Eating for pleasure is a sign of moral weakness.
79. I am prone to outbursts of anger or rage.
80. I feel that people give me the credit I deserve.
81. I have to be careful of my tendency to abuse alcohol.
82. I believe that relaxing is simply a waste of time.
83. Others would say that I get irritated easily.
84. I feel like I am losing out everywhere.

(Continued)

85. I experience marked mood shifts.
86. I am embarrassed by my bodily urges.
87. I would rather spend time by myself than with others.
88. Suffering makes you a better person.
89. I know that people love me.
90. I feel like I must hurt myself or others.
91. I feel that I really know who I am.

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EDI-2 ANSWER SHEET

David M. Garner, Ph.D.

Name _____ Date _____

Fill in your name and the date above. Follow the Instructions in the EDI-2 Item Booklet and enter your ratings on this sheet.

A = ALWAYS U = USUALLY O = OFTEN S = SOMETIMES R = RARELY N = NEVER

1	A U O S R N	20	A U O S R N	39	A U O S R N	58	A U O S R N	76	A U O S R N
2	A U O S R N	21	A U O S R N	40	A U O S R N	59	A U O S R N	77	A U O S R N
3	A U O S R N	22	A U O S R N	41	A U O S R N	60	A U O S R N	78	A U O S R N
4	A U O S R N	23	A U O S R N	42	A U O S R N	61	A U O S R N	79	A U O S R N
5	A U O S R N	24	A U O S R N	43	A U O S R N	62	A U O S R N	80	A U O S R N
6	A U O S R N	25	A U O S R N	44	A U O S R N	63	A U O S R N	81	A U O S R N
7	A U O S R N	26	A U O S R N	45	A U O S R N	64	A U O S R N	82	A U O S R N
8	A U O S R N	27	A U O S R N	46	A U O S R N			83	A U O S R N
9	A U O S R N	28	A U O S R N	47	A U O S R N	65	A U O S R N	84	A U O S R N
10	A U O S R N	29	A U O S R N	48	A U O S R N	66	A U O S R N	85	A U O S R N
11	A U O S R N	30	A U O S R N	49	A U O S R N	67	A U O S R N	86	A U O S R N
12	A U O S R N	31	A U O S R N	50	A U O S R N	68	A U O S R N	87	A U O S R N
13	A U O S R N	32	A U O S R N	51	A U O S R N	69	A U O S R N	88	A U O S R N
14	A U O S R N	33	A U O S R N	52	A U O S R N	70	A U O S R N	89	A U O S R N
15	A U O S R N	34	A U O S R N	53	A U O S R N	71	A U O S R N	90	A U O S R N
16	A U O S R N	35	A U O S R N	54	A U O S R N	72	A U O S R N	91	A U O S R N
17	A U O S R N	36	A U O S R N	55	A U O S R N	73	A U O S R N		
18	A U O S R N	37	A U O S R N	56	A U O S R N	74	A U O S R N		
19	A U O S R N	38	A U O S R N	57	A U O S R N	75	A U O S R N		

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Jeffrey A. Hoffman, Ph.D.
703 Northwood Terrace
Silver Spring, MD 20902

Dear Colleague:

I am sending you a copy of the Psychological Separation Inventory and the scoring key as requested. Below is a table of means and standard deviations for the various scales. Please do not combine the scales for a total psychological separation scorce since the various scales are not at positively correlated. Please feel free to reproduce the PSI and to use it for research, clinical or teaching purposes. I am sorry that I do not have reprints available to send to you. I hope that you will not have any difficulty making a copy from the journal of Counseling Psychology. If so, please write back and I will make a copy to send to you. For additional research, see: Hoffman, J. and Weiss, B., Family Dynamics and Presenting Problems in College Students, Journal of Counseling Psychology, 1987, V. 34, No. 2.

Thank you and good luck.

Sincerely,

Jeffrey A. Hoffman, Ph.D.

Table. Psychological Separation Inventory Means and Standard Deviations For a Random Sample of White College Students From Intact Families (N = 190).

	Males (N=83)				Females (N-107)			
	Father		Mother		Father		Mother	
Scales	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
FI	34	11	36	10	35	11	31	10
EI	47	13	49	12	44	14	42	13
CI	83	16	84	13	82	14	80	15
AI	27	12	29	10	27	11	25	11

Note. FI = functional independence;
EI = emotional independence;
CI = conflictual independence;
AI = attitudinal independence.

Taken from: Hoffman, Jeffrey A. "Presenting Problems and Family Dynamics of College Students", Dissertation, University of North Carolina - Chapel Hill, 1985.

PSYCHOLOGICAL SEPARATION INVENTORY

Instructions: The following list of statements describes different aspects of students' relationships with both their mother and father. Imagine a scale ranging from 1 to 5 that tells how well each statement applies to you. In the space next to the statement, please enter a number from "1" (Not at all true of me) to "5" (Very true of me). If the statement does not apply enter "1". Please be completely honest. Your answer are entirely confidential and will be useful only if they accurately describe you.

Not at all true of me	A little bit true of me	Moderately true of me	Quite a bit true of me	Very true of me
1	2	3	4	5

___1. I like to show my friends pictures of my mother.
___2. Sometimes my mother is a burden to me.
___3. I feel longing if I am way from my mother for too long.
___4. My ideas regarding racial equality are similar to my mother's.
___5. My mother's wishes have influenced my selection of friends.
___6. I feel like I am constantly at war with my mother.
___7. I blame my mother for many of the problems I have.
___8. I wish I could trust my mother more.
___9. My attitudes about obscenity are similar to my mother's.
___10. When I am in difficulty I usually call upon my mother to help me out of trouble.
___11. My mother is the most important person in the world to me.
___12. I have to be careful not to hurt my mother's feelings.
___13. I wish that my mother lived nearer so I could visit her more frequently.
___14. My opinions regarding the role of women are similar to my mother's.
___15. I often ask my mother to assist me in solving my personal problems.
___16. I sometimes feel like I'm being punished by my mother.
___17. Being away from my mother makes me feel lonely.
___18. I wish my mother wasn't so overprotective.
___19. My opinions regarding the role of men are similar to my mother's.
___20. I wouldn't make a major purchase without my mother's approval.
___21. I wish my mother wouldn't try to manipulate me.
___22. I wish my mother wouldn't try to make fun of me.
___23. I sometimes call homejust to hear my mother's voice.
___24. My religious beliefs are similar to my mother's.
___25. My mother's wishes have influenced my choice of major at school.
___26. I feel that I have obligations to my mother that I wish I didn't have.
___27. My mother expects too much from me.
___28. I wish I could stop lying to my mother.
___29. My beliefs regarding how to raise children are similar to my mother's.
___30. My mother helps me to make my budget.
___31. While I am home on a vacation I like to spend most of my time with my mother.
___32. I often wish that my mother would treat me more like an adult.
___33. After being with my mother for a vacation I find it difficult to leave her.
___34. My values regarding honesty are similar to my mother's.
___35. I generally consult with my mother when I make plans for an out of town weekend.
___36. I am often angry at my mother.
___37. I like to hug and kiss my mother.
___38. I hate it when my mother makes suggestions about what I do.
___39. My attitudes about solitude are similar to my mother's.
___40. I consult with my mother when deciding about part-time employment.
___41. I decide what to do according to whether my mother will approve of it.
___42. Even when my mother has a good idea I refuse to listen to it because she made it.
___43. When I do poorly in school I feel I'm letting my mother down.
___44. My attitudes regarding environmental protection are similar to my mother's.
___45. I ask my mother what to do when I get into a tough situation.
___46. I wish my mother wouldn't try to get me to take sides with her.
___47. My mother is my best friend.

___48. I argue with my mother over little things.
___49. My beliefs about how the world began are similar to my mother's.
___50. I do what my mother decides on most questions that come up.
___51. I seem to be closer to my mother than most people my age.
___52. My mother is sometimes a source of embarrassment to me.
___53. Sometimes I think I am too dependent on my mother.
___54. My beliefs about what happens to people when they die are similar to my mother's.
___55. I ask for my mother's advice when I am planning my vacation time.
___56. I am sometimes ashamed of my mother.
___57. I care too much about my mother's reactions.
___58. I get angry when my mother criticizes me.
___59. My attitudes regarding sex are similar to my mother's.
___60. I like to have my mother help me pick out the clothing I buy for special occasions.
___61. I sometimes feel like an extension of my mother.
___62. When I don't write my mother often enough I feel quilty.
___63. I feel uncomfortable keeping things from my mother.
___64. My attitudes regarding national defense are similar to my mother's.
___65. I call my mother whenever anthing goes wrong.
___66. I often have to make decisions for my mother.
___67. I'm not sure I could make it in life without my mother.
___68. I sometimes resent it when my mother tells me what to do.
___69. My attitudes regarding mentally ill people are similar to my mother's.
___70. I like to show my friends pictures of my father.
___71. Sometimes my father is a burden to me.
___72. I feel longing if I am away from my father for too long.
___73. My ideas regarding racial equality are similar to my father's.
___74. My father's wishes have influenced my selection of friends.
___75. I feel like I am constantly at war with my father.
___76. I blame my father for many of the problems I have.
___77. I wish I could trust my father more.
___78. My attitudes about obscenity are similar to my father's.
___79. When I am in difficulty I usually call upon my father to help me out of trouble.
___80. My father is the most important person in the world to me.
___81. I have to be careful not to hurt my father's feelings.
___82. I wish that my father lived nearer so I could visit him more frequently.
___83. My opinions regarding the role of women are similar to my father's.
___84. I often ask my father to assist me in solving my personal problems.
___85. I sometimes feel like I'm being punished by my father.
___86. Being away from my father makes me feel lonely.
___87. I wish my father wasn't so overprotective.
___88. My opinions regarding the role of men are similar to my father's.
___89. I wouldn't make a major purchase without my father's approval.
___90. I wish my father wouldn't try to manipulate me.
___91. I wish my father wouldn't try to make fun of me.
___92. I sometimes call home just to hear my father's voice.
___93. My religious beliefs are similar to my father's.
___94. My father's wishes have influenced my choice of major at school.
___95. I feel that I have obligations to my father that I wish I didn't have.
___96. My father expects too much from me.
___97. I wish I could stop lying to my father.
___98. My beliefs regarding how to raise children are similar to my father's.
___99. My father helps me to make my budget.
___100. While I am home on a vacation I like to spend most of my time with my father.
___101. I often wish that my father would treat me more like an adult.
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___131. When I don't write my father often enough I feel guilty.
___132. I feel uncomfortable keeping things from my father.
___133. My attitudes regarding national defense are similar to my father's.
___134. I call my father whenever anything goes wrong.
___135. I often have to make decisions for my father.
___136. I'm not sure I could make it in life without my father.
___137. I sometimes resent it when my father tells me what to do.
___138. My attitudes regarding mentally ill people are similar to my father's.

DEBRIEFING STATEMENT

The purpose of this study is to identify the implications of a psychosomatic family on the eating disorder known as anorexia nervosa. In particular, focusing on the two characteristics that have been found most significant in the onset of anorexia nervosa, which is enmeshment and overprotectiveness (Perosa et al, 1993). Understanding the psychological mediators between family interaction and psychopathology will help in both the prediction and the treatment of eating disorders. Specifically, my hypothesis is that two characteristics of the "psychosomatic family", enmeshment and overprotectiveness, will significantly influence or be related to an individual's etiology and maintenance of the eating disorder, anorexia nervosa.

I am hoping not only to find that the characteristics of an enmeshed and overinvolved family increases an individual's risk of obtaining anorexia nervosa but further that these characteristics influence the maintenance of anorexia nervosa. I choose Albion College as my source of data collection in hope of targeting the population most at risk which is white, upper middle class females. Furthermore, adolescence is the prime time for the onset of eating disorders, therefore, I selected only to survey the freshman women, currently experiencing the transition from childhood to adulthood.

Anyone who has experienced any emotional, physical or mental discomfort, please feel free to contact myself, Shannon McGoun at (312) 943-6545(day) or (312) 935-9814 (evening). Available on Albion's campus is the Albion College Health Center at 629-0220 which can be of assistance in referrals. In the event that you have suffered any discomfort as a result of participation in this research, you may contact the Chairperson of the Institutional Review Board for the Protection of Human Subjects of Loyola University at (312) 508-2471.

Thank you once again for your participation. It was greatly appreciated.

TABLE 1.1

PSYCHOLOGICAL SEPARATION INVENTORY

SUBSCALE	SAMPLE MEAN	TOTAL POSSIBLE
Functional Independence-Mother	26.5	65
Functional Independence-Father	35.3	65
Emotional Independence-Mother	36.6	85
Emotional Independence-Father	42.0	85
Conflictual Independence-Mother	71.3	125
Conflictual Independence-Father	74.8	125
Attitudinal Independence-Mother	23.7	70
Attitudinal Independence-Father	28.1	70
TOTAL:	350.8	690

*A higher number means greater psychological separation. The closer the sample mean to the total possible score, the more psychological separation.

TABLE 1.2

EATING DISORDER INVENTORY - 2

SUBSCALE	SAMPLE MEAN	PERCENTILE
Drive for Thinness	7.3	73rd
Bulimia	13.8	99th
Body Dissatisfaction	5.9	42nd
Ineffectiveness	16.4	99th
Perfectionism	3.4	36th
Interpersonal Distrust	10.3	98th
Interoceptive Awareness	13.5	99th
Maturity Fears	8.8	98th

*A higher rating reflects more extreme attitudes and behaviors about eating and body image. Percentile means i.e. 73 % of a nonpatient college sample had more extreme concerns and preoccupation with dieting than this college sample. All of the above information leads us to assume that this particular sample is healthier than other samples.

TABLE 1.3

CORRELATION COEFFICIENTS

	FUNC M	FUNC F	EMOT M	EMOT F	CONF M	CONF F	ATTI M	ATTI F
DT	-.1369	-.1581	-.0054	-.1249	.0341	.0213	-.0877	-.0266
B	-.1763	-.0908	-.0296	-.0564	-.2195	-.2090	-.0195	.0696
BD	-.1583	-.1406	-.0981	-.0664	.1729	.0609	-.1785	-.0980
I	.0124	.0856	-.0567	.1040	-.0924	-.2565	.0882	.2541
P	-.0699	-.0545	.1008	.0263	-.1886	-.1071	-.0808	-.1086
ID	**.4163****	**.3950***	**.4122***	**.3934***	-.2100	**.4388****	.2276	**.4135****
IA	.0011	.2239	.0648	.2126	-.1271	**-.3373***	.2848	**.4332****
MF	-.2044	.0964	-.2563	.0113	-.0354	-.1777	-.1074	.0480
A	-.1620	-.2996	-.0018	-.1101	-.2356	-.0779	-.0135	-.0601
IR	.0251	.1317	.1466	.1239	-.1654	-.2813	-.1405	.1871
SI	.2010	.2249	.1670	.2718	-.1146	**.4562****	.2408	**.4307****

Note. PSI Subscales: FUNCM = Functional Independence-Mother, FUNCF = Functional Independence-Father, EMOTM = Emotional Independence-Mother, EMOTF = Emotional Independence-Father, CONFM = Conflictual Independence-Mother, CONFF = Conflictual Independence-Father,ATTIM = Attitudinal Independence-Mother, ATTIF = Attitudinal Independence-Father. EDI Subscales: DT = Drive for Thinness, B = Bulimia, BD = Body Dissatisfaction, I = Ineffectiveness, P = Perfectionism, ID = Interpersonal Distrust, IA = Interoceptive Awareness, MF = Maturity Fears, A = Asceticism, IR = Impulse Regulation, SI = Social Insecurity. * = Significant at the .05 level. ** = Significant at the .01 level.

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VITA

I completed my undergraduate degree in May of 1994 from Albion College. Albion College is a small, private school in Michigan. I graduated with a Liberal Arts degree and a major in Psychology. I used my knowledge of Psychology in the following areas while at Albion College: a student mentor for the Albion public school system; a crisis line volunteer at a teenage runaway shelter; and a social work intern for the Albion public school system. During my four years at Albion, I spent a semester abroad in Stirling, Scotland and studied clinical psychology.

Currently, I am working full-time as a substance abuse counselor at a methadone clinic in Chicago. I completed my internship at this clinic and have been full-time since January of 1996. I am looking for other opportunities in the counseling field in order to further my experience. I will graduate from the masters program at Loyola University in January of 1997. I am in the process of submitting applications to doctoral programs for Fall of 1997.

In the future, I hope to have my doctorate in clinical psychology and teaching at the college level. Ideally, I would like to work with the adolescent population, in particular, with eating disorders.

Through my education and recent clinical experience, I realize there is still so much for me to learn. I look forward to furthering my education and improving my skills and knowledge in the counseling profession.

THESIS APPROVAL SHEET

The thesis submitted by Shannon McGoun has been read and approved by the following committee:

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The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the committee with reference to content and form.

The thesis is, therefore, accepted in partial fulfillment of the requirements for the degree of counseling psychology.

11-21-96 Elizabeth Vera

Date Signature